Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brett Marrs a prisoner at HMP Wymott on 4 September 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Brett Marrs died on 4 September 2018, after being found unresponsive in his cell at HMP Wymott. He was 41 years old. I offer my condolences to Mr Marrs' family and friends.

The cause of Mr Marrs' death has yet to be verified and will be determined at the Coroner's inquest. Toxicology tests revealed that morphine (consistent with heroin use) and psychoactive substances (PS) were present in blood samples, at levels known to cause death in even habitual drug users

Mr Marrs' physical healthcare was equivalent to the standard he could have expected in the community. Mr Marrs also received a high standard of clinical and psychosocial support to help address his substance misuse.

However, care for his mental health did not meet this standard, as some referrals to the mental health team were not followed up and he did not receive specialist counselling to address unresolved childhood abuse issues which he felt were a trigger for his use of drugs.

I am concerned that, despite a comprehensive substance misuse strategy, drugs are still freely available at Wymott, as Mr Marrs was reportedly able to obtain PS daily. The prison will need to reassess their approach in line with the Prison Service's recently published Prison Drugs Strategy.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **July 2019**

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Summary

Events

1. Mr Brett Marrs was remanded to HMP Liverpool on 14 November 2016, having been recalled to prison. (He was subsequently convicted of violent offences and received an extended sentence of 12 years.)

2. Mr Marrs was dependent on heroin and cocaine and a prison GP initially prescribed a methadone maintenance regime. Mr Marrs' began detoxification from methadone in May 2017.

3. Mr Marrs transferred to HMP Buckley Hall on 12 October. However, he felt threatened by other prisoners and moved to HMP Wymott on 29 November 2017. A substance misuse nurse at Wymott assessed Mr Marrs, created a care plan and held regular reviews with him. His detoxification had been suspended at Buckley Hall, but was resumed on 10 April 2018 and he completed it on 6 June.

4. During reviews with the substance misuse nurse in July and August, Mr Marrs said that he wanted formal support from the drug and alcohol service to become drug-free and admitted that he used PS daily. He was also found under the influence of PS in a workshop and on his wing.

5. Mr Marrs' behaviour deteriorated and intelligence reports suggested that he was involved in illicit activities. There was a suspicion that he enforced the repayment of debts on behalf of other prisoners involved in illicit activities, and it was possible that he received drugs as payment for this role.

6. Mr Marrs' cellmate said that on the evening of 3 September, Mr Marrs had smoked PS and heroin. In the early hours of 4 September, he heard Mr Marrs snoring unusually loudly (often a sign of opiate overdose).

7. At 8.14am, Mr Marrs was found unresponsive in his bed. Attempts to resuscitate him were unsuccessful and a paramedic confirmed his death at 9.12am.

8. The cause of death has yet to be established, but toxicology tests found morphine and PS at levels known to have caused death in even habitual drug users.

Findings

9. Wymott has a comprehensive and up to date substance misuse and PS strategy, to help reduce the supply of and demand for drugs. It includes clear processes for managing and supporting prisoners suspected of misusing drugs. In spite of this, it appears that drugs are readily available and Mr Marrs was able to obtain PS every day.

10. Mr Marrs received a high standard of clinical and psychosocial support to help address his substance misuse.

11. Staff arranged for Mr Marrs to be monitored by healthcare staff when he appeared to be under the influence of illicit substances. However, they did not follow some of the expected steps to address his drug use.

12. Overall, Mr Marrs' physical healthcare was of a good standard and equivalent to that he could have expected to receive in the community.

13. However, the clinical reviewer identified some deficiencies which did not contribute to Mr Marrs' death. When Mr Marrs transferred to Wymott, he did not receive a secondary health screen and use of the National Early Warning Score, a tool to assess unwell patients, was inconsistent.

14. Mr Marrs' mental health care fell below expected standards at Wymott and his previous prisons, Liverpool and Buckley Hall. Referrals were not followed up and an identified need for specialist counselling was not addressed.

15. The wing officer who unlocked Mr Marrs' cell did not conduct a welfare check, as is expected. We have made recommendations about this in previous investigations into deaths at Wymott.

16. When Mr Marrs was found unresponsive a few minutes later, an officer radioed the correct emergency code, but there was a delay in calling an ambulance. Although this did not affect the outcome for Mr Marrs, it is essential that staff comply with the requirement to call an ambulance immediately in these circumstances. We have made recommendations about this in previous investigations into deaths at Wymott.

Recommendations

- The Governor should ensure that the key drug issues at Wymott are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.
- The Governor should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drug strategy.
- The Head of Healthcare should ensure that all new prisoners are offered a secondary health screen.
- The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS) to assess prisoners effectively.
- The Heads of Healthcare at HMP Liverpool, HMP Buckley Hall and HMP Wymott should ensure that there is a robust and auditable process to action and follow up mental health referrals. Outstanding assessments should be brought to the attention of the receiving establishment when a prisoner transfers.
- The Governor should ensure that the importance of checking prisoners before unlocking them is incorporated into local staff training.
- The Governor should ensure that, for the next three months, a manager checks that an ambulance has been called immediately following receipt of a medical emergency code.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

18. The investigator obtained copies of relevant extracts from Mr Marrs' prison and medical records.

19. NHS England commissioned a clinical reviewer to review Mr Marrs' clinical care at the prison. The investigator and clinical reviewer interviewed six members of staff at Wymott on 22 November 2018. The investigator also interviewed a prisoner on the same day.

20. Our investigation was suspended while waiting for the cause of death. This has delayed the initial report.

21. We informed HM Coroner for Coroner for Lancashire and Blackburn with Darwen of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

22. The investigator contacted Mr Marrs' sister, his next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. Mr Marrs' sister had a number of questions about how Mr Marrs was managed and the circumstances leading to his death, including:

    - Did Mr Marrs receive drug treatment and was he prescribed methadone?
    - How did Mr Marrs acquire and afford drugs?
    - What did Mr Marrs do on 3 September?
    - Was the cell call bell activated?
    - The prison provided an incorrect date of birth leading to errors on the death certificate and Mr Marrs' casket.
    - Why was Mr Marrs' family initially told that they could not speak to Mr Marrs' cellmate?

23. We have addressed the issues that fall within our remit in our report.

24. Mr Marrs' sister received a copy of our initial report. She raised a number of issue and questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out three factual inaccuracies and this report has been amended accordingly. They accepted our recommendations and their action plan has been annexed to this report.

Background Information

HMP Wymott

26. HMP Wymott is a medium secure prison which holds over 1,100 adult men. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services and Geometric Results International provides GP services and out of hours care, including 24-hour nursing cover.

HM Inspectorate of Prisons

27. The most recent inspection of Wymott was in October 2016. Prisoners told inspectors that drugs were freely available and in the inspection survey, 63% of respondents said that it was easy to obtain illicit drugs, which was higher than at comparable prisons (43%). Prisoners and staff were aware of the dangers of PS and had said that it was available on the wings.

28. Inspectors found that the substance misuse strategy had improved, with effective communication and links between the safer prisons, security, offender management and drug strategy teams. This included a specific action plan to reduce the use of PS. Security and drug strategy meetings were well attended and detailed information-sharing took place between relevant departments.

29. In respect of processes, inspectors noted that all new arrivals were screened for substance misuse problems and about two thirds of prisoners had received support for drug and alcohol problems. Details in security information reports, prisoners' records and police reports were used to inform interventions. Drug testing after suspected use was too low, as testing staff were unavailable, but this had increased in line with requests from prison staff. Inspectors also noted that there was a broad mix of individual and group support activities, as well as good peer support. Dedicated nurses and visiting specialist substance misuse consultants assisted the drug services team; treatment regimes were flexible and reviewed regularly; and relationships between the psychosocial and clinical teams were excellent.

Independent Monitoring Board

30. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2018, the IMB reported that the standard of healthcare was poor and frequently fell below that which could be expected in the community. The Board also noted that increased bullying and debt had led to violence. The use of PS had resulted in injuries to prisoners and a high number of requests for ambulances, but improved strategies for dealing with such incidents had reduced the number of calls towards the end of the reporting year.

Previous deaths at HMP Wymott

31. Mr Marrs' death was the 14th at Wymott since January 2017 and there have been two subsequent deaths. Three of the previous deaths were linked to the use of illicit substances.

32. We have made previous recommendations about calling an ambulance promptly and ensuring the wellbeing of prisoners when they are unlocked.

Psychoactive Substances (PS)

33. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

34. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

35. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

36. Mr Brett Marrs was remanded to HMP Liverpool on 14 November 2016. He had been recalled to prison while on licence in the community. (Mr Marrs was later convicted of several offences, including robbery and possession of heroin. He received an extended sentence of 12 years, with a custodial period of eight years and an extension of four years.)

HMP Liverpool

37. At reception health screens, Mr Marrs told healthcare staff that he was dependent on drugs, using around £300 of heroin and crack cocaine a day. He had also been prescribed mirtazapine, an antidepressant, by his community GP. Mr Marrs was referred to Lifeline Drug and Alcohol Recovery Service. A prison GP prescribed methadone, initially titrated (started at a low dose and increased daily) over five days, followed by a maintenance dose. (Methadone is a synthetic opioid used in the treatment of heroin addiction.)

38. During his first few months at Liverpool, Mr Marrs received one-to-one structured substance misuse counselling, which covered harm minimisation issues such as tolerance levels, overdose awareness, the damage caused by psychoactive substances and the risks of death. He completed in-cell workbooks on heroin and crack cocaine awareness, but declined to participate in groupwork or set targets as he said he wanted to focus on the offending behaviour programmes in his sentence plan.

39. At a counselling session on 27 April 2017, a healthcare support worker noted that a drug test had been negative for illicit substances and Mr Marrs had asked for monthly tests to maintain his motivation. He told Ms O'Neill that he self-medicated with illicit substances due to childhood abuse issues and she referred him for talking therapies to address this. A male therapist was assigned in June, but Mr Marrs said he would prefer a female therapist. He was therefore taken off the list to wait for a female counsellor to become available. Mr Marrs continued to have one-to-one substance misuse counselling throughout his time at Liverpool.

40. Once sentenced, Mr Marrs was expected to detoxify from methadone. At the 13 and 26-week substance misuse reviews, on 14 February and 22 May respectively, Mr Marrs was not willing to consider this. Nevertheless, he was referred for detoxification and it was recorded on 25 May that he had agreed on a reduction of 2ml (from 40ml) every two weeks.

41. On 26 September, after participating in a rooftop protest against the ban on smoking, Mr Marrs tied a ligature around his neck. Staff monitored him for two days under the Prison Service suicide and self-harm prevention procedures and referred him urgently to the mental health team. He told a nurse that he was struggling with nicotine withdrawal and methadone reduction and his mental health was suffering. The next day, a prison GP diagnosed depression and prescribed mirtazapine.

42. On 30 September, staff called a medical emergency code as they were concerned about Mr Marrs. A nurse reviewed Mr Marrs, who was suspected of

using PS. Mr Marrs and his cellmate reported difficulty breathing and admitted smoking tobacco, but denied drug use. Due to the smell of possible PS in the cell, the nurse was unable to complete clinical observations.

Transfer to HMP Buckley Hall

43. On 12 October 2017, Mr Marrs transferred to HMP Buckley Hall. At that time, he was on 20ml of methadone. His medication was continued and he was referred to the drug and alcohol recovery service.

44. On 17 October 2017, a nurse conducted an initial substance misuse assessment. Mr Marrs said he eventually wanted to be opiate-free, but asked to suspend his methadone detoxification and remain on a stabilisation dose for the time being as he did not feel mentally stable. He added that his act of self-harm the previous month was due to reducing methadone against his wishes. The same day, a recovery worker reviewed Mr Marrs and asked for a recovery practitioner to be allocated to him.

45. Mr Marrs isolated himself in his cell for the next two weeks as he believed he was under threat from other prisoners and was worried that they were poisoning his food. During that time, he missed GP and substance misuse appointments. He moved to another wing, but remained concerned about his safety and referred himself to the mental health team. Wing staff took his meals to his cell and allowed him to shower and use the telephone when other prisoners were locked in their cells.

46. On 7 November, Mr Marrs' detoxification was suspended and it was agreed that he would remain at 16ml. After an assessment on 9 November, Mr Marrs decided to have no further contact with the mental health team.

Transfer to HMP Wymott

47. As Mr Marrs continued to be fearful of other prisoners, he was transferred to HMP Wymott on 29 November. After an initial health screen with a nurse, Mr Marrs' methadone and mirtazapine were continued. He was also referred to the mental health team. Mr Marrs did not have a secondary health screen.

48. On 6 December, a nurse conducted a substance misuse review. He increased the dosage of methadone from 16ml to 20ml, as Mr Marrs felt the lower dose was insufficient. He told the nurse that he had been intoxicated on PS when he had made the noose three months before and they discussed harm reduction and overdose in depth. They planned to reconsider a methadone reduction in the new year, once Mr Marrs had settled at Wymott.

49. Between 7 and 11 December, Mr Marrs was monitored as a victim under the prison's tackling anti-social behaviour procedures. He told staff problems had followed him from another prison, he had been physically threatened and feared for his safety. He then moved to another wing.

50. In January 2018, Mr Marrs declined to engage formally with the substance misuse service. On 19 January and 6 February, he refused to provide a sample for a mandatory drug test. However, drug screening tests on 8 February and 7 March showed no evidence of illegal or non-prescribed drugs.

51. On 7 March, a substance misuse nurse conducted an initial substance misuse assessment and took an oral swab for drug testing (which was negative). The nurse later created a substance misuse care plan.

52. A nurse reviewed Mr Marrs on 16 March, with a drug and alcohol recovery worker. Mr Marrs said he felt stable on 20ml of methadone and it was agreed to keep him on that dose. He also wanted to begin working with the Building Futures Drug and Alcohol Recovery Service. The nurse updated Mr Marrs' substance misuse care plan to reflect that he would engage with psychosocial interventions and the clinical team on a one-to-one basis, and an assessment was arranged for him to be considered for group work with Building Futures.

53. On 20 March, a nurse went to see Mr Marrs as he had asked to start methadone reduction. He said he felt well and ready to do this. The nurse explained the process and they began to set goals. She also advised Mr Marrs that once the reduction plan was agreed, it would not be stopped unless there was a significant deterioration in his physical or mental health, so if he was unsure or changed his mind at any time during the assessment period, he should tell staff and the assessment would end.

54. At a follow-up meeting on 4 April, the nurse and Mr Marrs discussed and completed a motivation map looking at the advantages and disadvantages of starting a detoxification. Mr Marrs presented very few negatives and said he would prefer to reduce at 2ml per week. The nurse reiterated that a reduction plan could not be reversed. The case was discussed at a multidisciplinary team meeting that afternoon. Mr Marrs agreed and signed an updated care plan on 6 April and began methadone reduction on 10 April, to be reviewed fortnightly. A test on that day was negative for illicit drugs.

55. Healthcare staff reviewed Mr Marrs weekly and initially there were no concerns. On 24 May, when his dose was 6ml, he felt unwell. He said he had expected this, but was managing it well and was not taking any illicit drugs.

56. On 31 May, Mr Marrs was involved in a fight in which he was said to have been the main aggressor and had assaulted another prisoner. When questioned, he passed it off as a play fight. However, he was disciplined and lost the privileges of television, association and gym for seven days.

57. Mr Marrs received his final dose of methadone on 6 June. Nurses gave him medication to manage withdrawal symptoms and prescribed zopiclone, a sleeping tablet. He chose not to engage with Building Futures, but was due to have monthly post-detoxification reviews. (A drug test on 19 June was negative.)

58. In June and July, there were several instances of indiscipline. In the early hours of 11 June, Mr Marrs was one of a group of prisoners openly discussing their use of drugs and passing items through their cell windows. During an intelligence-led search of Mr Marrs' cell on 12 June, wing officers found drug equipment believed to be used for PS and two debt lists relating to other prisoners, listing items they owed and their monetary value. Mr Marrs' response to the find was, "Fair enough, I don't care anyway."

59. On 15 June, Mr Marrs admitted that he had a phone charger, an unauthorised item. On 19 June, staff found a makeshift screwdriver in his cell. On 24 June, intelligence suggested that a group of prisoners had called another prisoner to a cell and Mr Marrs had then gone into the cell and assaulted him, accusing him of being a grass. On 4 July, intelligence information linked Mr Marrs to a threat of assault. Mr Marrs also missed several sessions of work during this period and received a warning letter.

60. Mr Marrs had his first monthly review with a nurse on 10 July. He said that he was feeling well, but had started using PS daily, mostly at night due to boredom. The nurse warned Mr Marrs of the dangers and risks of using PS and referred him to Building Futures.

61. On 12 July, an Instructional Officer noted that Mr Marrs was unable to stand still while being searched when leaving the engineering workshop. He denied taking drugs, but his speech was slurred. The officer warned him that substance abuse in the workshop would not be tolerated.

62. The next day, a nurse was called to examine Mr Marrs in the workshop as he was again believed to be under the influence of PS. Mr Marrs denied taking any substances. He was monitored in his cell. No National Early Warning Score (NEWS) was calculated during monitoring. (NEWS is a tool to determine the severity of illness, based on vital signs.) Mr Marrs lost his job in the workshop and subsequent applications to work as a wing cleaner or in the servery were refused.

63. On 29 July, Mr Marrs was assisted back to his cell by an officer after being found under the influence of PS.

64. Mr Marrs agreed to engage with Building Futures. On 2 August, he signed a compact to remain drug-free and to be subject to a programme of voluntary drug testing. He listed the substances he used as PS, heroin and methadone. He said that he wanted to join the prison's therapeutic community in the new year but, in the meantime, agreed to join the PS rolling programme. Mr Marrs completed a recovery action plan, setting out his needs, goals (including to be PS-free) and action required, and he received advice on harm minimisation.

65. At his second post-detoxification review on 3 August, Mr Marrs told a nurse that he had reduced the amount of PS, but still used it daily. He said he was mentally and physically well. The nurse reiterated the advice about the dangers of using PS.

66. On 7 August, intelligence records noted that Mr Marrs took the blame for possessing a weapon that belonged to another prisoner. On 16 August, it was noted in the wing observation book that just before he was locked up the previous night, Mr Marrs was seen staggering to his cell and was not his usual self.

67. On 21 August, Mr Marrs attended a Building Futures group session and completed a further recovery action plan.

68. The same day, Mr Marrs was one of several prisoners in a cell where an altercation took place and one of the prisoners appeared to have been assaulted.

69. On 23 August, after a warning for refusing to attend work, Mr Marrs asked to be sacked from his job in a workshop.

Events of 2, 3 and 4 September

70. Mr Marrs had shared a cell on C Wing with his cellmate since 27 July. They had known each other for around ten years from previous prisons. There were no intelligence reports or other evidence to indicate that Mr Marrs' cellmate either used or supplied drugs at Wymott. In a statement and at interview he said that Mr Marrs smoked PS in their cell. He said that on 2 September, after smoking PS at around 6.00pm, Mr Marrs' arms and legs were twitching and he was struggling to breathe. He had vomited on the floor and his cellmate left it there so that he could show it him when he became more conscious.

71. Towards the end of evening association on 3 September, an officer locked Mr Marrs' cell. The cell call bell was activated at 6.48pm. An officer answered it and found that another prisoner had been locked in with them. Mr Marrs walked out with the prisoner, saying he had to collect something from another (unnamed) prisoner. (The cell call bell was not activated during the night.)

72. When Mr Marrs returned from association, he told his cellmate that he had some PS and a small wrap of heroin and he then smoked them. His cellmate later helped him onto the top bunk. Sometime between 3.00am and 4.00am, his cellmate woke up and heard Mr Marrs breathing loudly. He was used to him snoring, but had not heard him breathing that heavily before. He was not concerned, as he believed Mr Marrs to be conscious.

73. Just after 8.00am on 4 September, an officer unlocked cells on C Wing, including Mr Marrs' cell, and went to supervise the methadone treatment queue. After some time, the treatment nurse said she was still waiting for Mr Marrs' cellmate to collect his methadone. The officer went to his cell and pushed the door open. The cell was in darkness, but his cellmate woke up and the officer told him that his methadone was ready. The officer said that Mr Marrs' cellmate went to the medication hatch about two minutes later.

74. An officer was on the landing just outside Mr Marrs' cell. His cellmate went over to him and said that he could not wake Mr Marrs up. The officer went into the cell and tried to rouse him. Mr Marrs appeared not to be breathing, so the officer called a code blue (an emergency response code which indicates that a prisoner is unresponsive or has breathing difficulties) at 8.14am.

75. A nurse reached the cell. She said Mr Marrs was not breathing and looked grey. Several officers arrived. They removed Mr Marrs from the top bunk and placed him on the floor. An officer started chest compressions and the nurse took over, assisted by other nurses and officers. They used a defibrillator (a device that gives an electric shock to the heart of someone in cardiac arrest), which advised no shock. They then inserted an airway and used an Ambu bag for ventilation and took turns to continue the chest compressions until the paramedics arrived at 8.34am.

76. The paramedics continued the resuscitation attempts with advanced life support. However, this was unsuccessful and a paramedic confirmed Mr Marrs' death at 9.12am.

Contact with Mr Marrs' family

77. Later that morning, the deputy governor and the prison's family liaison officer (FLO) visited Mr Marrs' sister, his next of kin, to break the news of Mr Marrs' death. They offered condolences and provided information about the processes to be followed.

78. The FLO kept in touch with Mr Marrs' sister over the following weeks and liaised with the undertakers. After consulting a prison manager, the FLO had initially refused permission for Mr Marrs' family to speak to his cellmate. However, this request was later approved.

79. Mr Marrs' funeral was held on 14 September. In line with national policy, the prison contributed to the funeral expenses.

Support for prisoners and staff

80. After Mr Marrs' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

81. The chaplain and a prison manager supported Mr Marrs' cellmate. Staff checked the wellbeing of other prisoners on the wing and reviewed those assessed as being at risk of suicide or self-harm, in case they had been adversely affected by Mr Marrs' death. The prison posted notices informing other staff and prisoners of Mr Marrs' death and offering support.

Post-mortem report

82. A digital autopsy was carried out. This is an alternative to a traditional post-mortem examination (in which the body is opened and the organs removed for examination). In a digital autopsy, the body is scanned using a CT scanner, and the data from the scan is then processed to create a detailed 3D reconstruction of the body. Specially trained radiologists and pathologists can then examine the visual to look for clues as to the cause of death.

83. The digital autopsy did not identify an underlying cause for Mr Marrs' death.

84. Toxicology tests found morphine (consistent with heroin use), PS and mirtazapine (an antidepressant, which Mr Marrs had been prescribed) in Mr Marrs' post-mortem blood samples.

85. The toxicology report noted that the combination and level of drugs in Mr Marrs' system has been known to cause death in even chronic and tolerant drug users. It also highlighted that severe toxic effects, such as rapid loss of consciousness, cardiopulmonary arrest and death, have been reported after use of some psychoactive substances.

Findings

Drug Strategy at HMP Wymott

86. Following an inspection in October 2016, HM Chief Inspector of Prisons was concerned that drugs were freely available at Wymott. The prison revised and reissued their substance misuse strategy in August 2018, setting out a number of actions to reduce the demand and supply of illicit drugs. The strategy includes a protocol for the management of prisoners suspected of misusing PS and a "Robust Recovery Package" with a flowchart for staff, concisely setting out the actions to be taken. It is a concern that, despite these measures, Mr Marrs was able to obtain drugs daily and suggests that much more needs to be done to tackle the issue of drugs at Wymott.

87. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works. We welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

88. In relation to reducing the supply of drugs, the new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

We, therefore, recommend:

The Governor should ensure that the key drug issues at Wymott are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

Support for substance misuse

Clinical and psychosocial support

89. Mr Marrs had a long history of substance misuse in the community. In prison, several drug tests had been negative for illicit substances. Mr Marrs was initially on methadone maintenance, but began methadone reduction in April 2018, which he completed in June. A nurse regularly reviewed his progress and risks. She updated his care plans and repeatedly gave him advice on risks and harm minimisation.

90. On 10 July, Mr Marrs told the nurse that he was using PS and they also discussed it at a subsequent review. In early August, Mr Marrs decided to

engage with Building Futures. At interview, the nurse said that she was initially bound by patient confidentiality on the disclosure of the use of PS, but after Mr Marrs had agreed to work with the drug and alcohol recovery service, she was able to pass on this information.

91. The clinical reviewer concluded that Mr Marrs' substance misuse care at Wymott was "of a high standard in both delivery, consistency and in the patient centred approach employed". She also noted clear evidence of the application of lessons learned since the investigation of a previous drug-related death at Wymott. We are satisfied that Mr Marrs received prompt and appropriate clinical support during his drug treatment and after detoxification.

Action on intelligence reports and suspected PS use

92. Mr Marrs' cellmate said that Mr Marrs smoked PS every day. He said PS was always available, but heroin was not as common. He said that Mr Marrs did not buy PS, drugs were given to him, he was not coerced into taking them and he was not involved in dealing drugs. Another prisoner said he had known Mr Marrs since June 2018 and was aware that he smoked PS regularly.

93. In the early hours of 4 September, Mr Marrs' cellmate heard Mr Marrs snoring differently and more loudly than usual. He was not concerned as there were no signs that Mr Marrs was unwell or unconscious. People who die from an overdose of opiates become deeply unconscious, unarousable and are often heard to be snoring heavily before they stop breathing. Although we cannot be certain, particularly in the absence of a confirmed cause of death, it was possible that the loud snoring Mr Marrs' cellmate heard was a symptom of drug-induced unconsciousness.

94. On 9 September, intelligence was received that a (named) prisoner had been receiving drugs through the post and was alleged to have supplied the PS that Mr Marrs had taken shortly before his death.

95. Intelligence information linked Mr Marrs to various suspicious activities and indicated that he worked as an enforcer for other prisoners who were involved in bullying, drugs conveyance and other illicit behaviour. The role of an enforcer is to intimidate others to pay debts, etc. If this was the case, it was likely that Mr Marrs received payment for this activity in the form of drugs and this would be consistent with Mr Marrs' cellmate's assertion that Mr Marrs was given drugs and did not pay for them. The Head of Security said it was difficult to act immediately on uncorroborated intelligence information, but further monitoring would usually take place. She also said that the amount of cumulative intelligence information on Mr Marrs was not unique and, given resources, had to be handled on a priority and risk basis.

96. Wymott's local PS protocol includes a Robust Recovery Pathway. This specifies several steps to be taken in all instances of suspected PS use, such as consideration of downgrading to basic level under the incentives and earned privileges scheme; and a referral for the two-week Robust Recovery Intervention Programme, or other interventions. Another strand is that the regular multidisciplinary team meeting should discuss any prisoner whose illicit drug use combined with their prescribed drug is a cause for concern, so that decisions can

be made about future prescribing. The Head of Reducing Reoffending said that Mr Marrs had not come to the attention of the prison's Robust Recovery meetings.

97. Mr Marrs had engaged with the substance misuse services a few weeks before his death. However, we are concerned that when he appeared to be under the influence of PS, there is no evidence of action other than monitoring by healthcare and wing staff. We make the following recommendation:

The Governor should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drug strategy.

Clinical care

98. The clinical reviewer considered that Mr Marrs' physical healthcare was of a reasonable standard, equivalent to that he could have expected to receive in the community, although she identified some weaknesses which did not impact on his death.

99. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, gives guidance on the clinical management of prisoners. As well as initial health assessments, the PSO requires prisons to offer every prisoner a general health assessment to gather and provide further information and check how the prisoner is settling. They should do this in the week after their reception. Mr Marrs did not receive a secondary health screen. We make the following recommendation:

The Head of Healthcare should ensure that all new prisoners are offered a secondary health screen.

100. When Mr Marrs was suspected of being under the influence of PS on 13 July, healthcare staff monitored him, but did not complete a NEWS assessment. NEWS allows staff to determine the severity of illness and early detection of deterioration. The omission did not impact on Mr Marrs' death, but given the potentially serious consequences of taking illicit drugs, such assessments should be used routinely when a prisoner is unwell. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS) to assess prisoners effectively.

101. Mr Marrs had partly attributed his substance misuse to blocking feelings relating to childhood abuse. Healthcare staff at HMP Liverpool had made some effort to arrange therapy, but this was not followed up.

102. The clinical reviewer found that Mr Marrs' mental health care at Wymott and previous prisons was not of an acceptable standard. No formal mental health assessment took place; some referrals to the primary mental health team were not followed up; and the need for access to specialist counselling was identified but not pursued. The clinical reviewer concluded that Mr Marrs' mental health care was not equivalent to that he could have expected in the community. We recommend:

The Heads of Healthcare at HMP Liverpool, HMP Buckley Hall and HMP Wymott should ensure that there is a robust and auditable process to action and follow up mental health referrals. Outstanding assessments should be brought to the attention of the receiving establishment when a prisoner transfers.

103. The clinical reviewer made additional recommendations, unrelated to the probable cause of Mr Marrs' death.

Unlocking cells

104. Wymott's notice to staff, *Unlocking of Cell Doors*, issued on 8 January 2015, sets out the expected procedures for unlocking prisoners. As a precaution and for their own safety, officers are expected to make a visual check of the cell through the observation hatch, using the lighting provided, if necessary, before unlocking the door. They should then ensure the wellbeing of the prisoner and gain some form of response, particularly when prisoners have been locked up for a long period.

105. An officer unlocked Mr Marrs' cell on 4 September. At interview, he said that every time he had unlocked that cell it was always in darkness with both occupants asleep. He always had to wake Mr Marrs' cellmate to get his methadone.

106. Although only a few minutes had elapsed and it might have made no difference to the outcome for Mr Marrs, we are concerned that the relevant checks were not made to establish the welfare of both men when the cell was first unlocked. In response to informal feedback given during the investigation, Wymott has recently reissued a notice to staff, reminding them of the procedures for unlocking cell doors and confirming the wellbeing of prisoners. As we have raised this issue before, however, we consider that more needs to be done and we recommend that:

The Governor should ensure that the importance of checking prisoners before unlocking them is incorporated into local staff training.

Emergency response

107. PSI 03/2013, *Medical Emergency Response Codes* and Wymott's notice to staff 40/2018 *Medical Emergency Response Code Protocol* sets out the actions staff should take in a medical emergency. It contains mandatory instructions on efficiently communicating the nature of a medical emergency and stipulates that if an emergency code is called over the radio, an ambulance must be called immediately.

108. An officer called a code blue emergency promptly when he found Mr Marrs unresponsive and the control room log gives the impression that an ambulance was called immediately. However, the ambulance service records show that the call was received at 8.18am, four minutes after the emergency code. While we are satisfied that this delay did not affect the outcome for Mr Marrs, in other emergencies such a delay could be critical. We identified similar concerns in our report of an investigation into another death at Wymott, shortly before that of Mr Marrs. In response, the prison reissued guidance to staff in December 2018,

with a reference copy visibly displayed in the control room. Managers also spoke to control room staff, individually, to remind them of the expected actions following an emergency response code. As we have raised this issue before, we make the following recommendation to ensure that learning is embedded:

The Governor should ensure that, for the next three months, a manager checks that an ambulance has been called immediately following receipt of a medical emergency code.

109. The clinical reviewer noted that the resuscitation attempts were efficient and compliant with Resuscitation Council UK guidelines.

Family contact

Mr Marrs' date of birth

110. Mr Marrs' sister was concerned that the date of birth the prison gave to the coroner and funeral director was incorrect and led to inaccuracies on Mr Marrs' death certificate and funeral casket.

111. Mr Marrs had given several different dates of birth to various criminal justice agencies (possibly linked to aliases) and there were multiple dates in prison records. Wymott told us that the date of birth officially recorded in Mr Marrs' personal records was that given on the warrant from the court and therefore could not be altered without permission from the court. Mr Marrs would have confirmed this date of birth on reception and he did not make an application to get it changed at any time. If he had done so, the process would have required the prison to submit a copy of his birth certificate to the court. If agreed, the sentencing judge would authorise the court to amend the records and provide a new Order of Imprisonment. Prison staff would then have had the authority to amend the date in their records and list the incorrect one as an alias.

112. It is unfortunate that this led to errors on the death certificate and casket and we recognise that this would have been distressing for Mr Marrs' family.

Request to speak to Mr Marrs' cellmate

113. Mr Marrs' sister said that a request for a family member to speak to Mr Marrs' cellmate was refused, but was granted after representations from the family.

114. The prison told us that the request was initially refused as Mr Marrs' death was sudden and unexpected and they needed to secure potential evidence. As Mr Marrs' cellmate was a key witness, they did not want to risk compromising the police investigation, so they waited until the police had confirmed that they had concluded their enquiries. The prison's family liaison officer consulted a prison manager after each request from the family.

115. We are satisfied that the prison had reasonable cause to delay access to Mr Marrs' cellmate.

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